DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 2 3

2. STATE: MONTANA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 070101

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.272

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ 1,607,667
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachement 4.19A, Pages 1-8

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19A, Pages 1-7A, 8

10. SUBJECT OF AMENDMENT: Reimbursement for inpatient hospital

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Single State Agency Director

12. SIGNATURE OF STATE AGENCY OFFICIAL: Michael S Billings for

13. TYPED NAME: Gail Gray Director

14. TITLE: Director

15. DATE SUBMITTED: 28 September 2001

16. RETURN TO:
Department of Public Health & Human Services
Gail Gray Director
Attn: Denny Gemmell
PO Box 202951
Helena MT 59620

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: October 3, 2001

18. DATE APPROVED: 12/21/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL: Spencer K. Ericson

21. TYPED NAME: Spencer K. Ericson

22. TITLE: Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: September 28, 2001

FORM HCFA-179 (07-92)

Instructions on Back

REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES

A. MONTANA MEDICAID PROSPECTIVE PAYMENT (DRG) REIMBURSEMENT

Except for those exempt hospitals and units identified in subsection C, reimbursement for inpatient hospital services will be made using the Prospective Payment Method. Effective for discharges related to admissions occurring on or after October 1, 1987, the Montana Medicaid Program will pay for inpatient hospital services according to a Diagnosis Related Group (DRG)-based payment system.

Because of the complexity of this reimbursement system, the following documents have been attached as an appendix:

1. Administrative Rules of Montana;
2. Revised weights and thresholds contained in Addendum 'A';
3. Montana Medicaid Inpatient Hospital Provider Manual;
4. Documentation from the public rule hearing; and
5. Signatures from the hospital Chief Executive Officers supporting the draft language for Qualified Rate Adjustment Payments.

Effective July 1, 2001 for hospitals located in the state of Montana and out of state hospitals within 100 miles of the Montana border subject to Montana Medicaid DRG reimbursement, the DRG base is increased to $2125 as a result of a legislative provider rate increase. Hospitals located in the state of Montana are paid an interim rate for the facility specific capital related expense. Out of state hospitals state hospitals within 100 miles of the Montana border subject to Montana Medicaid DRG reimbursement are paid the statewide average of $229 for capital add-on. The statewide cost to charge ratio remains at 56%.

Hospitals and units that are exempt from this reimbursement method will be reimbursed on a retrospective cost basis. Exempt hospitals and units are identified in subsection C of this state plan.

B. DETERMINATION OF PAYMENT

Upon the discharge or transfer of each patient, hospitals submit a bill to Montana Medicaid which will provide, among other information, the patient's principal diagnosis, additional diagnoses, principal and secondary procedures, age and sex. These variables are passed through a DRG grouper program to determine the appropriate DRG for each discharge. Although hospitals may indicate the anticipated DRG on the billing invoice when it is submitted for payment, the Medicaid grouper program is the final determinant in assigning the payable DRG to each case.

The Medicaid grouper for admissions on or after October 1st of each year is identical to the current version of the Medicare grouper.

Most DRGs, with the exception of 469 and 470, will have a relative value assigned to be used in the determination of reimbursement. This relative value is multiplied by the DRG Base rate to determine the Gross DRG Payment Amount and any outlier amounts. The Gross DRG Payment Amount is then reduced by any reported Third Party Liability Amount, Copayment Amount, Medicare Payment Amount and Patient Responsibility (Spend-down). (Some DRGs that are uncommon in Montana do not have a weight assigned. These DRGs are paid at allowed charges multiplied by the statewide cost to charge ratio.)

A number of DRG codes have been extended to recognize the differences in intensity of care between children and adults and between large referred hospitals and other DRG hospitals. The DRG extensions are as follows:

- To designate the DRG for children versus adults, a fourth digit has been added to the DRG. A "1" in that position indicates this is a pediatric DRG. A "2" in the fourth position indicates this is an adult DRG.

- To designate the DRG for large hospitals versus other DRG hospitals, a fifth digit has been added to the DRG. A "1" in the fifth position indicates this DRG applies to all DRG hospitals except for the six large referral hospitals. A "2" in the fifth position indicates the DRG applies only to the six large referral hospitals.

C. EXEMPT HOSPITALS, UNITS AND COSTS

Some providers and costs are exempt from prospective payment.

1. The following are subject to retrospective cost reimbursement principles:

   A. Hospitals in rural and very rural counties in Montana, effective July 1, 1993. Rural and very rural counties are identified by the United States Department of Agriculture in their urban to rural continuum.
   B. Neonate services under DRGs 385-389 provided in neonatal intensive care units of Montana hospitals are exempt from the Medicaid DRG payment system and will be reimbursed using a retrospective cost-based system effective July 1, 1993. Interim payments will be based on facility charges times the facility cost-to-charge ratio determined from submitted cost reports.
   C. Rehabilitation units of acute care hospitals. These units will be issued a distinct Medicaid provider number. Units will be required to submit a cost

report, on an annual basis after the provider fiscal year end, detailing the costs of providing these services.

D. Medical Education related costs as defined by Medicare.
E. Certified Registered Nurse Anesthetists costs as defined by Medicare.
F. Critical Access Hospitals as licensed by the State.

2. The following are reimbursed 61% of billed charges for medically necessary services for date of admission on/after March 1, 2001:

A. Hospitals located more than 100 miles from the Montana border.
B. Border facilities which provide services that are not available in Montana to a major portion of Montana Medicaid recipients.

D. REASONABLE COST REIMBURSEMENT

Hospitals, units and costs exempt from prospective payment will continue to use the Title XVIII retrospective reasonable cost principles for reimbursing Medicaid inpatient hospital services. Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American institute of Certified Public Accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual, HCFA Pub. 15-1, subject to the exceptions and limitations provided in the Department's Administrative Rules. Pub. 15, is a manual published by the United States Department of Health and Human Services, Health Care Financing Administration, which provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended.

Hospitals subject to retrospective reasonable cost reimbursement shall receive interim payments during the facility's fiscal year. The interim payment will be based on a percentage of customary charges as determined by the facility's Medicaid cost report. If a provider fails to submit financial information to compute the rate, the provider will be reimbursed at 50% of its usual and customary billed charges.

E. OUTLIERS

Cases that have been identified as unusually high cost are eligible for additional outlier payments if they exceed the thresholds for outlier status.

Cost outliers are cases with costs that exceed the cost outlier threshold for the DRG. To determine if a hospital stay exceeds the cost outlier threshold, the Montana Medicaid Program excludes all services provided which are not medically necessary. Montana Medicaid then

converts the charge information for medically necessary services into cost information by applying a statewide average cost-to-charge ratio. The cost for the medically necessary services is then compared to the cost outlier threshold for the appropriate DRG to determine if the case qualifies for reimbursement as a cost outlier. Costs exceeding the threshold are multiplied by a marginal cost ratio (60%) to determine the outlier reimbursement amount.

F. UNSTABLE and EXEMPT DRGs

Effective for dates of service on/after July 1, 2001, Montana Medicaid no longer classifies certain DRG weights as "unstable". Therefore, all DRGs except for the "Exempt" DRGs are paid relative value assigned multiplied by the DRG base in addition to any outlier amounts and facility specific add-on expenses.

"Exempt" DRGs are uncommon in Montana and do not have a weight assigned. These DRGs are paid at the allowed charges times the statewide cost-to-charge ratio.

G. CATASTROPHIC CASES

Effective for admissions on/after July 1, 2001, cases that exceed the Catastrophic Case Threshold of billed charges of $144,000 are eligible for consideration for additional reimbursement. Upon review by the designated review organization to verify medical necessity, catastrophic claims may be paid the estimated cost of the inpatient hospital stay by multiplying allowed charges by the statewide cost-to-charge ratio.

Providers will receive the base DRG payment and any appropriate outlier payments for each catastrophic case through the regular claims payment process, and shall receive as a catastrophic case claim an amount equal to the estimated cost less the base DRG payment amount and any applicable outlier payment amounts.

H. EXEMPT STAYS (HOSPITAL RESIDENT)

A recipient who is unable to be cared for in a setting other than an acute care hospital and who meets the following requirements is classified as a hospital resident:

1. A patient must utilize a ventilator for a continuous period of not less than 8 hours in a 24 hour period or require at least 10 hours of direct nursing care in a 24 hour period;
2. A patient must have been an inpatient in an acute care hospital for a minimum of 6 continuous months;

3. The provider will have the responsibility of determining whether services could have been provided in a skilled nursing care facility or by a home and community based waiver program. If services could have been provided in a less restrictive setting, then resident status will not be granted.

Payment for hospital residents will be made as follows:

1. Payment for the first 180 days of inpatient will be the DRG payment and any appropriate outliers; and
2. Payment for all medically necessary patient care subsequent to 180 days will be reimbursed at a rate computed by multiplying the statewide average cost-to-charge ratio by the usual and customary billed charges.

I. TRANSFERS

For dates of services prior to July 1, 1999, when a patient was transferred between hospitals, the transferring hospital was paid a per diem rate for each medically necessary day of care provided to the recipient prior to transfer up to the full DRG plus any appropriate outlier. For dates of services on or after July 1, 1999, when a patient is transferred between hospitals, the transferring hospital is paid a per diem rate of two times the average per diem amount for the first inpatient day of care provided to the recipient prior to the transfer up to the full DRG plus any appropriate outlier.

The hospital that ultimately discharges the patient receives the full DRG payment plus any appropriate outliers or, if they are exempt from DRG reimbursement, they will receive regular payment as a discharging hospital.

Occasionally, a patient is transferred from one hospital to another and then when the condition that caused the transfer is alleviated, back to the original hospital. Thus, a hospital can be both a transferring and discharging hospital. Under these circumstances, the original hospital is also the discharging hospital and should submit two claims. The hospital that treated and transferred the patient back to the original hospital is considered the transferring hospital and is eligible for the per diem.

When a patient is moved from an acute care bed to a rehabilitation unit bed, this is considered a discharge for payment purposes.

All transfers are subject to review for medical necessity of the initial as well as subsequent hospitalizations and the medical necessity of the transfer itself. Reimbursement cannot be made to a provider unless the service provided was medically necessary.

J. READMISSIONS

All readmissions are subject to review for medical necessity of the initial as well as the subsequent hospitalization and the medical necessity of the readmission itself. Reimbursement cannot be made to a provider unless the service provided was medically necessary. Readmissions may be reviewed on a retrospective basis to determine if additional payment for the case is warranted.

K. UNBUNDLING

Services provided on the day of admission or on the day preceding the day of admission are included in the DRG. These services were deemed to be inpatient services before prospective payment and were included in the DRG calculation. This includes any outpatient services (including observation) provided within 24 hours of admission. All routine services (e.g., room and board, nursing) are included in the DRG payment. All diagnostic service (e.g., radiology) are included in the first hospital's DRG payment. Arrangement for payment to the second hospital where the services were actually performed must be between the first and second hospital. All ancillary services provided by the hospital or performed by another entity (e.g., hospital has a contractual agreement with an enrolled independent laboratory) are included in the DRG payment.

Physician services are excluded from the DRG payment and shall be billed separately.

L. DISPROPORTIONATE SHARE PROVIDERS

Hospitals providing services to a disproportionate share of Medicaid recipients shall receive an additional payment amount as computed below.

To be deemed eligible for a disproportionate share payment adjustment, the hospital must meet the following criteria:

1. A Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or a low income utilization rate that exceeds twenty percent (20%);
2. A Medicaid inpatient utilization rate of at least one percent (1%); and
3. A hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area (that is, an area outside of a Metropolitan Statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any

physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

4. Section 3 does not apply to a hospital which:
   A. The inpatients are predominantly individuals under 18 years of age; or
   B. Does not offer non-emergency obstetric service as of December 22, 1987.

The Medicaid inpatient utilization rate (expressed as a percentage) for a hospital shall be computed as a total number of Medicaid inpatient days for a hospital in a cost reporting period, divided by the total number of inpatient days in the same period.

1. "Medicaid inpatient day" means the hospital's number of inpatient days attributable to patients who were eligible for medical assistance under the approved Medicaid State Plan in a cost reporting period (whether the patients receive medical assistance on a fee-for-service basis or through a managed care program).
2. "Inpatient Day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

The low income utilization rate for a hospital shall be computed as the sum (expressed as a percentage) of the fraction is calculated as follows:

1. Total Medicaid patient revenues including fee for service and managed care programs paid to the hospital, plus the amount of cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of cash subsidies) in the same reporting period; and
2. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. Total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under the State Plan) that is, reductions in charges given to other third party payers, such as HMO'S, Medicare and Blue Cross.

The additional payment will be an amount equal to the product of the hospital's Medicaid operating cost payment times the hospital's Medicaid disproportionate share adjustment percentage developed under rules established under Section 1886 (d) (5) (F) (iv) of the Social Security Act.

M. HOSPITAL POLICY ADJUSTOR

Hospitals located in Montana paid via the prospective payment system who meet the following criteria: has 50 or fewer beds; routinely delivers babies; delivered less than 200 babies (all payors) for state fiscal year 2000 (July 1, 1999 through June 30, 2000) and of the total babies delivered in state fiscal year 2000, 53% were covered with Medicaid primary or Medicaid secondary. Data sources for the Department to confirm who meets the criteria include but is not limited to: Montana Hospital Association database; Montana Medicaid paid claims database; Department's database for vital statistics; and licensing bureau within the Department.

Subject to funding, hospitals qualifying for the "Hospital Policy Adjustor" will receive, in addition to the DRG payment, a payment amount of 5% of the hospital's prospective base rate. The Montana Hospital Association supports the implementation of the "Hospital Policy Adjustor" as many small hospitals located near Indian Reservations have higher percentages of Medicaid births.

N. QUALIFIED RATE ADJUSTMENT (QRA) PAYMENT

In accordance with the Code of Federal Regulation "447.272 Inpatient Services: Application of Upper Payment Limits: (2) Non-state government-owned or operated facilities (that is, all government facilities that are neither owned nor operated by the State)", a hospital located in Montana meeting this definition may be eligible for a Qualified Rate Adjustment Payment. If the eligible hospital's most recently reported costs multiplied by 150% (Upper Payment Limit) are greater than the Montana Medicaid allowed payment for inpatient care, the eligible hospital will receive a Qualified Rate Adjustment payment of the difference. The submitted cost reports from eligible hospitals and information from the paid claims database will be used for calculations. The QRA payment must be for services (paid claims) on or after July 1, 2001. Within the contract period between the Department and the eligible hospital, the Department will reconcile to ensure the Medicaid allowed and the QRA payments do not exceed ~~the facility's Upper Payment Limit per year.~~ 150% of the hospital's costs of providing services per year.

O. APPEAL RIGHTS

Providers contesting the computation of interim payments or final settlement for capital and medical education costs; coding errors resulting in incorrect DRG assignment; medical necessity determinations; outlier determinations; or, determinations of readmission and transfer shall have the opportunity for a fair hearing in accordance with the procedures set forth in ARM 37.5.310.

P. PUBLIC PROCESS

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.